STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155193	A. BUILDING _____ B. WING _____	C 02/12/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB-GREENWOOD	377 WESTRIDGE BLVD GREENWOOD, IN 46142

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

This visit was for the Investigation of Complaints IN00142766, IN00142938, IN00143002 and IN00143853.

Complaint IN00142766 - Substantiated. No deficiencies related to the allegations are cited.
Complaint IN00142938 - Substantiated. No deficiencies related to the allegations are cited.
Complaint IN00143002 - Substantiated. No deficiencies related to the allegations are cited.
Complaint IN00143853 - Substantiated. No deficiencies related to the allegations are cited.

Survey dates:
February, 7, 10, 11 and 12, 2014

Facility number: 000101
Provider number: 155193
AIM number: 100291290

Survey team:
Diana Zgonc, RN-TC

Census bed type:
SNF/NF: 164
Total: 164

Census payor type:
Medicare: 52
Medicaid: 101
Other: 11
Total: 164

Sample: 6

Kindred Transitional Care-Greenwood was found to be in compliance with 42 CFR Part 483,

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155193	A. BUILDING _____ B. WING _____	C 02/12/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB-GREENWOOD	**377 WESTRIDGE BLVD GREENWOOD, IN 46142**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 1 Subpart B and 410 IAC 16.2 in regard to the Investigation of Complaints IN00142766, IN00142938, IN00143002, IN00143853. Quality Review 02/13/14 by Lisa McColly	F 000		